

**Resolution 1-F08. Expressing Concern about the Certifying Examination for Doctor of Nursing Practitioner (DNP)**

(Sponsor: District of Columbia Chapter)

WHEREAS, some 200 schools of nursing plan to grant an advanced doctorate degree for nurse practitioners (DNP); and

WHEREAS, the National Board of Medical Examiners intends to provide a certifying examination for this degree specifically utilizing questions from Step III of the physician licensing examination; and

WHEREAS, the American Medical Association and the American Academy of Family Practice expressed concern that the public and other medical professionals could confuse and misinterpret the DNP certification as equivalent to physician certification or could potentially use DNP certification to expand the scope of nurse practitioner practice; therefore be it

**RESOLVED, that the Board of Regents recommends that the American College of Physicians join with the American Medical Association and the American Academy of Family Practice to express its concern that the National Board of Medical Examiners chooses to provide a certifying examination for the Doctor of Nursing Practitioner (DNP) degree that specifically uses questions from Step III of the physician licensing examination; and be it further**

**RESOLVED, that the Board of Regents recommends that the DNP certifying process not include the Step III process as it may lead to confusion and misinterpretation, but rather include a testing process that demonstrates specific expertise within the scope of nursing practice alone, with the disclaimer that DNP certification is not recognition of a background or training equivalent to that of a physician.**

## **Resolution 2-F08. Changing the Order of the American College of Physicians' Goals as Stated in the 2008 Strategic Plan**

(Sponsor: Arizona Chapter)

WHEREAS, the American College of Physicians (hereafter referred to as "The College") is a membership organization incorporated to serve the needs of its members; and

WHEREAS, the College has a comprehensive strategic plan introduced in January 2008 outlining the seven major goals; and

WHEREAS, the College's planning systematically addresses four interrelated perspectives, each critical to the members' success including:

- Value – setting goals to provide valuable programs, products and services (PPSs), advocacy, policies and partnerships.
- Financial – setting goals to insure financial stability/growth to support our strategies.
- Business strategies – setting goals for marketing our PPSs, communicating with members, and growing membership.
- Organizational infrastructure and operations – setting goals to insure that our staff, internal systems and procedures support our goals for value, financial stability and business strategies; and

WHEREAS, the College then develops focused objectives for each of the goals each fiscal year representing high-level priorities guided by objectives, driven by initiatives and evaluated and tracked by performance indicators; and

WHEREAS, the order of the goals in the College's 2008 Strategic Plan are as presented:

### **COLLEGE GOALS**

- I. To establish and promote the highest clinical standards and ethical ideals;
- II. To be the foremost comprehensive education and information resource for all internists;
- III. To advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members;
- IV. To serve the professional needs of the membership, support healthy lives for physicians, and advance internal medicine as a career;
- V. To promote and conduct research to enhance the quality of practice, the education and continuing education of internists, and the attractiveness of internal medicine to physicians and the public;
- VI. To recognize excellence and distinguished contributions to internal medicine; and
- VII. To unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession; and

WHEREAS, all the goals listed in the College's 2008 Strategic Plan represent the College's highest level activity guiding all the other objectives and initiatives; therefore be it

**RESOLVED, that the Board of Regents changes the order of stated goals to reflect the essential nature of the American College of Physicians as a membership organization to serve the needs of its members. The order of the goals is changed and prioritized as follows:**

**COLLEGE GOALS**

- I. To serve the professional needs of the membership, support healthy lives for physicians, and advance internal medicine as a career;**
- II. To advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members;**
- III. To promote and conduct research to enhance the quality of practice, the education and continuing education of internists, and the attractiveness of internal medicine to physicians and the public;**
- IV. To establish and promote the highest clinical standards and ethical ideals;**
- V. To be the foremost comprehensive education and information resource for all internists;**
- VI. To recognize excellence and distinguished contributions to internal medicine; and**
- VII. To unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession; and be it further**

**RESOLVED, that the Board of Regents reaffirms the goals of the Strategic Plan representing the College's highest level priorities.**

**Resolution 3-F08. Surveying Governors to Determine the Financial Burden to Practicing Physicians that Serve as ACP Governor**

(Sponsor: BOG Class of 2010)

WHEREAS, an ACP Governor's term is, in effect, five years and requires a considerable amount of time devoted to chapter and national activities; and

WHEREAS, some Governors manage small full-time practices, lack institutional support, and incur considerable costs associated with being away from practice for College activities; and

WHEREAS, there may be a disproportionate financial burden for those Governors employed in small, full-time practices in comparison to institutionally-based Governors who do not usually incur any significant personal financial costs for being a Governor; and

WHEREAS, there may be barriers to practitioners being willing to serve as Governors, producing unwanted homogeneity in the pool of individuals who are willing to be elected to the Governor positions, and over time produce unwanted and skewed leadership input to the ACP, locally and nationally; and

WHEREAS, ACP provides other leadership positions with a modest remuneration for service; therefore be it

**RESOLVED, that the Board of Regents conducts:**

**a) a survey of current and recently past Governors to determine if there is a disproportionate financial burden for Governors who are in private practice versus Governors who practice in institutions; and**

**b) if it is found that there is a significant financial burden, that the Board of Regents considers solutions, including shortening the tenure of Governors or providing a *modest* stipend for Governors to *help* offset the loss of income and minimize this barrier to private practitioners volunteering to serve.**

**Resolution 4-F08. Providing ACP Chapters with the Option to Abstain from Incentive-Based Recruitment Programs**

(Co-Sponsors: Georgia, Atlantic Provinces, Hawaii, Nevada, Oklahoma, and Wisconsin Chapters)

WHEREAS, new members are essential to the continued growth and success of the national ACP and ACP chapters; and

WHEREAS, to remain financially viable, the American College of Physicians and ACP chapters must maintain current membership and recruit new members through collaborative partnerships; and

WHEREAS, recruitment of new members is a financial expense for both parties; and

WHEREAS, ACP policy provides discounted membership to new members at the expense of chapters by waiving chapter dues for the first year of membership which serves as a disincentive for chapters to participate in collaborative efforts; and

WHEREAS, the current Recruit-a-Colleague Program provides incentives and recognition to member recruiters and financial incentives to chapters; and

WHEREAS, the Recruit-a-Colleague Program for members requires only the recruiter's name on the application; and

WHEREAS, to obtain financial incentives a chapter must use a special application obtained from the national ACP office imprinted with a specific code; and

WHEREAS, this requirement places undue administrative hardship on chapters to enlist all chapter members in the recruitment process and provide chapter members with these special applications; and

WHEREAS, if this process is not followed, only the recruiting member receives the benefits offered in the program and chapters remain without either incentives or chapter dues derived from the new member; and

WHEREAS, many state chapters have adequate dues rates and find the administrative burden of adhering to such a program prohibitive; therefore be it

**RESOLVED, that the Board of Regents provides ACP chapters with the option to abstain from incentive-based recruitment programs and receive the annual chapter dues from all new members; and be it further**

**RESOLVED, that the Board of Regents provides that when a chapter chooses to opt out of incentive programs and a discount is mandated to be offered to new members, such discounts should be shared at a proportionately equal deduction of national and chapter dues (i.e. if the discount rate is 10%, this would apply to both dues rates).**

**Resolution 5-F08. Distributing a Portion of First-Year Membership Dues to ACP Chapters**

(Sponsor: Ohio Chapter)

WHEREAS, new members are essential to the continued growth and success of both ACP and its Chapters; and

WHEREAS, local peer-to-peer recruitment is essential to growth of new membership; and

WHEREAS, ACP currently waives Chapter dues for the first year of membership, which limits Chapter resources for participating in new member recruitment efforts; and

WHEREAS, enhanced support of Chapters has been called for to address concerns raised in the Resolution 23 Task Force deliberations; therefore be it

**RESOLVED, that the Board of Regents distributes a portion of all first-year membership dues to ACP Chapters; and be it further**

**RESOLVED, that the Board of Regents continues incentives for Chapters to engage in recruitment of new members, distributing an additional amount of first-year dues (beyond the new standard “dues distribution” to Chapters called for in the first resolve) to Chapters for their involvement in recruiting new Members, and streamline the Recruit-a-Colleague-Chapter process to better enable Chapters to sustain recruitment efforts.**

**Resolution 6-F08. Forgiving Chapter Dues for ACP Members Affected by a National Disaster**

(Sponsor: California Chapter)

WHEREAS, ACP has policy to support members in their practice of medicine; and

WHEREAS, natural disasters (such as wildfires in California and hurricanes in New Orleans/Gulf Coast) have impacted members and their practices in recent years; and

WHEREAS, other national medical societies are planning to forgive dues for a year for physicians who have lost their homes or offices due to the natural disasters; therefore be it

**RESOLVED, that the Board of Regents forgives annual dues for 1 year to members who have lost their homes or offices due to a federally declared disaster, and further**

**RESOLVED, that Board of Regents supports chapters to forgive chapter dues for 1 year for members who have lost their home or office due to a federally declared disaster.**

**Resolution 7-F08. Establishing a “Fast Track” Option for ACP Policy Review or Development**

(Sponsor: California Chapter)

WHEREAS, health and public policy issues may emerge rapidly; and

WHEREAS, ACP policy is to support members and their patients on health related issues; and

WHEREAS, the current process for developing or revising ACP policy frequently takes 6 months to a year or more even after approval by the Board of Regents; therefore be it

**RESOLVED, that the Board of Regents establishes a “fast track” option for chapters to utilize for ACP policy review or development on urgent legislative, health, or public policy issues.**

**Resolution 8-F08. Tracking Progress on BOG Resolutions**

(Sponsor: Southern California Region II)

WHEREAS, a Board of Governors' resolution frequently initiates ACP policy; and

WHEREAS, the average member has no way of easily tracking what further actions the Board of Regents or ACP national Committees take on a resolution; and

WHEREAS, ACP policy is to include/retain members who are interested in participating in policy development; therefore be it

**RESOLVED, that the Board of Regents posts quarterly on the members only section of its Web page the status/action for all resolutions passed by the ACP Board of Governors in the previous year; and be it**

**RESOLVED, that Board of Regents invites the author of every resolution passed by the BOG to provide testimony to the Regents and/or ACP Committee when the resolution is discussed.**

## **Resolution 9-F08. Implementing Universal State and Federal J-1 Visa Application Processes**

(Sponsor: Arizona Chapter)

WHEREAS, it is a goal of the College to serve the professional needs of the membership; and

WHEREAS, the College's member database indicates that international medical graduates (IMG) constitute 28% of all non-student members; and

WHEREAS, there is an impending collapse of primary care, and IMGs can and do serve as primary care internists providing a vital resource for the United States health care system, especially medically underserved populations; and

WHEREAS, the current process for obtaining permanent resident status is expensive and cumbersome for IMGs; and

WHEREAS, the Conrad 30 program is the major conduit by which IMGs can work in the U.S. and ultimately obtain permanent residency, currently limited to 30 J-1 visa IMGs per state, per year, for a total of 3 years; and

WHEREAS, the number of physicians working under the J-1 visa Conrad 30 program is shrinking and in some states the program remains increasingly unfilled; and

WHEREAS, it is in the best interest of medically underserved areas to fill the Conrad 30 program with qualified J-1 physicians; and

WHEREAS, J-1 visa processing to enter an accredited residency program sponsored by the ECFMG (Education Commission for Foreign Medical Graduates) is a 4 – 6 week approval process compared to J-1 visa process to enter the work force, which can take up to a year; and

WHEREAS, other professions, including but not limited to the nursing profession, have successfully advocated for an expedited naturalization process (Green Card process); and

WHEREAS, a sponsor can relieve a J-1 visa Conrad 30 physician from his duties, and the J-1 visa physician immediately becomes "out of status" with the Immigration and Naturalization Service (INS); and

WHEREAS, the Board of Regents has previously advocated for a streamlined process for obtaining J-1 and H1B visas for non-U.S. citizen international medical graduates who desire to train and subsequently work in the U.S.; therefore be it

**RESOLVED, that the Board of Regents works towards the implementation of universal and simplified state and federal J-1 visa application processes; and be it further**

**RESOLVED, that the Board of Regents advocates for changes to the Conrad 30 program that provide a fair distribution of J-1 visa physicians in the most medically underserved areas based on the total population of the state instead of the current set number of 30 physicians per state regardless of need and population; and be it further**

**RESOLVED, that the Board of Regents advocates on behalf of the Conrad 30 J-1 physicians to allow them to change sponsors among medically underserved areas without restriction within the Conrad 30 system; and be it further**

**RESOLVED, that the Board of Regents acts to permit Conrad 30 J-1 visa physicians a grace period of 120 days in order to find another Conrad 30 position if relieved of their duties.**

## **Resolution 10-F08. Seeking Legislation to Offer Loan Forgiveness for Primary Care Physicians**

(Sponsor: Iowa Chapter)

WHEREAS, the best opportunity for high quality, cost effective health care in the future includes the Patient-centered Medical Home concept which requires adequate numbers of primary care physicians of whom there is an impending critical shortage (1); and

WHEREAS, average medical school debt in 2007 was \$139,517 according to the Association of Medical Colleges (2) and students with debt exceeding \$150,000 are least likely to select a primary care residency (3); and

WHEREAS, only 20% of third year and 13% of first year Internal Medicine residents listed an interest in primary care in 2005 (4); and

WHEREAS, the American College of Physicians (4, 5) and the Association of American Medical Colleges (6) have recognized the need for medical school debt relief in order to reduce impediments to entering primary care specialties and that additional incentives may be required to allow students to choose primary care careers; therefore be it

**RESOLVED, that the Board of Regents seeks state and federal legislation in addition to the National Health Service Corps to offer loan forgiveness to any physician choosing a primary care specialty (general internal medicine, family medicine or general pediatrics) such that:**

- a) No interest accrues or payment is required during residency training,**
- b) 10% of the total debt be forgiven for each year for up to 10 years, including interest, commencing with entering primary care practice,**
- c) More rapid forgiveness, such as 20% per year be offered for practices located in high need geographic areas such as Health Professions Shortage areas, and**
- d) Payment of the accrued interest on the entire debt plus the unforgiven principal be required if such physician leaves primary care during the period of practice required for loan forgiveness, except for military or public service, illness, disability or death.**

Notes:

1. American College of Physicians. The impending collapse of primary care medicine and its implications for the state of the nation's health care: a report from the American College of Physicians. Philadelphia: American College of Physicians; 30 January 2006.
2. American College of Physicians. Statement for the record of the American College of Physicians to the Senate Committee on Health, Education, Labor and Pensions: Addressing healthcare workforce issues for the future. Philadelphia: American College of Physicians; 12 February 2008.
3. Rosblatt RA and Andrilla CHA. The impact of U.S. medical students' debt on their choice of primary care careers: An analysis of data from the 2002 medical school graduation questionnaire. *Academic Med.* 2005; 80:815-16.
4. American College of Physicians. Developing a Medicare buy-in program. Philadelphia: American College of Physicians; 2006: Position paper.
5. American College of Physicians. Achieving a high-performance health care system with universal access: What the United States can learn from other countries. *Ann Intern Med.* 2008; 148:55-75.
6. Association of American Medical Colleges. Medical educational costs and student debt: a working group report to the AAMC governance. Washington, D.C. 2005.

## **Resolution 11-F08. Seeking Federal Policy to Rebalance the Disparity between Reimbursement for Procedural vs. Evaluation and Management (E&M) Codes**

(Sponsor: Iowa Chapter)

WHEREAS, there exists an impending shortage of primary care physicians (1), and since high student educational debt coupled with a dysfunctional payment system that limits the income potential of primary care physicians are potent economic drivers of career decisions for medical students and residents (2); and

WHEREAS, strong primary care with adequate numbers of primary care physicians are characteristics of high-performing health care systems (3); and

WHEREAS, typical starting salaries for general internists are approximately 50% of procedural specialists with recent salary surveys showing a two to threefold difference between median salaries for established primary care physicians vs. proceduralists (4); and

WHEREAS, this large differential is created by undervaluing evaluation and management (E & M) services compared with procedural services, coupled with the flawed sustainable growth rate formula for Medicare payment calculations (1); and

WHEREAS, the American College of Physicians is already on record favoring reforms in determining the value of physician services under the Medicare fee schedule (1); therefore be it

**RESOLVED, that the Board of Regents seeks federal policy to direct the Center for Medicare and Medicaid Services (CMS) to begin immediately, and complete over 8-10 years, rebalancing the disparity between reimbursement for evaluation and management (E & M) codes and procedural codes.**

Notes:

1. American College of Physicians. The impending collapse of primary care medicine and its implications for the state of the nation's health care: a report from the American College of Physicians. Philadelphia: American College of physicians; 30 January 2006.
2. Rosenblatt RA and Andrilla CHA. The impact of US medical students' debt on their choice of primary care careers: an analysis of data from the 2002 medical school graduation questionnaire. *Academic Med.* 2005; 80: 815-16.
3. American College of Physicians. Achieving a high-performance health care system with universal access: What the United States can learn from other countries. *Ann Intern Med.* 2008; 148:55-75.
4. Bodenheimer T, Berenson RA, Rudolf P. The primary care-specialty income gap: why it matters. *Ann Intern Med.* 2007; 146: 301-6.

**Resolution 12-F08. Seeking Change in Federal Policy to Phase Out Medicare Geographic Payment Modifiers**

(Sponsor: Iowa Chapter)

WHEREAS, current Medicare payment policy creates 89 separate payment regions, all with different fee schedules adjusted according to Geographic Practice Cost Indices (GPCIs); and

WHEREAS, this practice creates up to a 38% difference in Medicare payment among different regions (1); and

WHEREAS, states near the bottom of the GPCI Medicare payment rates have difficulties with physician recruitment and retention; and

WHEREAS, there should be equal Medicare pay for equal work across the United States; therefore be it

**RESOLVED, that the Board of Regents seeks change in federal Medicare policy such that all geographic modifiers for Medicare reimbursements are completely phased out over no more than 8 years and that the practice expense Geographic Practice Cost Index be immediately given a floor value of 1.0 while this transition is begun.**

1. Kitchell M. Geographic equity in Medicare: Maintaining access for patients (equal pay for equal work). 29 August 2007. Presentation to the Iowa Medical Society Board of Directors

**Resolution 13-F08. Sponsoring Legislation to Update the Medicare Geographic Practice Cost Index**

(Sponsor: California Chapter)

WHEREAS, the Medicare Geographic Practice Cost Index (GPCI) has not been updated since 1992; and

WHEREAS, the cost of living/practicing medicine has significantly increased in many areas of the country during that time; and

WHEREAS, this distortion of physician reimbursement is impacting access to care for elderly patients in many counties/states; and

WHEREAS, changes to the GPCI formula require federal legislation and the Centers for Medicare and Medicaid Services (CMS) or individual ACP chapters cannot realize these changes alone; and

WHEREAS, ACP currently has no policy and has not supported recent federal legislation to fix this problem; therefore be it

**RESOLVED, that the Board of Regents works with other interested parties to sponsor legislation that will effectively update the Medicare Geographic Practice Cost Index (GPCI) and allow for future updates to occur on a regularly scheduled basis.**

**Resolution 14-F08. Seeking Legislation that Requires Durable Medical Equipment (DME) Companies to Provide Patients with Cost Information**

(Sponsor: New York Chapter)

WHEREAS, the length of hospital stays are becoming shorter and patients are being discharged with more Durable Medical Equipment (DME) needs; and

WHEREAS, health plans are covering less and less DME and patients must bear more of this expense; and

WHEREAS, patients have no ability to compare costs of the equipment they need or the quality of service that DME companies provide; therefore be it

**RESOLVED, that the Board of Regents seeks legislation requiring Durable Medical Equipment (DME) companies to provide patients, for whom DME has been prescribed, with information on costs as well as purchase and rental options; and be it further**

**RESOLVED, that the Board of Regents seeks legislation requiring DME companies to supply patients with equipment prescribed by their physician and to obtain approval from the prescribing physician if a substitution is required.**

**Resolution 15-F08. Requiring Payment for Physician Services and Diagnostic Tests Consequent to Formulary Requirements**

(Sponsor: New York Chapter)

WHEREAS, managed care companies are increasingly restricting physicians' choice of prescription medications; and

WHEREAS, the out-of-pocket cost to patients for their prescriptions is increasing; and

WHEREAS, physicians frequently change prescription medications in order to reduce the out-of-pocket cost to their patients; and

WHEREAS, additional office visits and laboratory testing may be required to safely manage these changes; therefore be it

**RESOLVED, that the Board of Regents seeks implementation of policies that require that payment for physician services and diagnostic tests consequent to formulary requirements and other payer policies not be denied; and be it further**

**RESOLVED, that the Board of Regents works with the American Medical Association to develop ICD 10 and/or CPT codes that reflect that services provided are consequent to payer requirements.**

**Resolution 16-F08. Seeking Legislation that Requires Medicare Coverage for Home Infusion of Antibiotics**

(Sponsor: New York Chapter)

WHEREAS, the United States spent an estimated 2.2 trillion dollars for health care in 2007; and

WHEREAS, 30% of this health care expenditure was for hospital care; and

WHEREAS, administering antibiotics in an outpatient setting can reduce the length of hospital stays and their associated costs; therefore be it

**RESOLVED, that the Board of Regents seeks federal legislation that requires Medicare coverage for home infusion of antibiotics, including both medication and administration services.**

**Resolution 17-F08. Providing Grants for Chapter-sponsored Patient Centered Medical Home Demonstration Projects**

(Sponsor: Texas Chapter)

WHEREAS, there is currently a shortage of primary care internists in the United States of America; and

WHEREAS, there are more physicians leaving than entering the primary care work force; and

WHEREAS, the American College of Physicians along with 16 nationally recognized physician organizations, the Patient Centered Primary Care Collaborative (representing over 100 large employers, health plans, consumer and physician provider groups), and various provisions in federal and state legislation have recognized and adopted the concept of the Patient Centered Medical Home (PCMH) as a mechanism to transform health care delivery in the United States of America; and

WHEREAS, the funding of demonstration projects necessary to successfully implement the PCMH championed by the ACP requires vigorous support; therefore be it

**RESOLVED, that the Board of Regents provides \$100,000 in seed grants to each qualified chapter that will initiate, lead, design and implement a Patient Centered Medical Home (PCMH) demonstration project; and be it further**

**RESOLVED, that the Board of Regents selects chapters for funding through a formal review process performed by a PCMH Grants Committee established for this purpose.**

**Resolution 18-F08. Clarifying the Relationship between the Patient Centered Medical Home and Subspecialty Care**

(Sponsor: District of Columbia Chapter)

WHEREAS, medical subspecialists contribute to the excellence of care in the U.S. and are encouraged to be members of the American College of Physicians; and

WHEREAS, the medical home model favored by the ACP presumably differs from the HMO model by not limiting access to subspecialty care; and

WHEREAS, there remains confusion within the ACP membership about how subspecialty care will be used and fit into the model concept; therefore be it

**RESOLVED, that the Board of Regents clarifies the process whereby subspecialists will function with the medical home, and how access to and free choice of specialists will be established.**

## **Resolution 19-F08. Examining Existing and Proposed Single Payer Models**

(Sponsor: New York Chapter)

WHEREAS, the American College of Physicians advocates universal health insurance coverage to ensure that all people within the United States have equitable access to appropriate health care without unreasonable financial barriers; and

WHEREAS, in order to achieve this goal, the ACP has recommended that federal and state governments adopt either a single payer or a pluralistic system; and

WHEREAS, the College has endorsed the Patient Centered Medical Home as a model for health care delivery; and

WHEREAS, the ACP has not endorsed any model of a single payer system; therefore be it

**RESOLVED, that the Board of Regents examines existing and proposed single payer models to determine if one meets the goal of universal, equitable access consistent with the Patient Centered Medical Home model; and be it further**

**RESOLVED, that the Board of Regents encourages multiple demonstration projects for the Patient Centered Medical Home for the purpose of obtaining evidence-based models; and be it further**

**RESOLVED, that the Board of Regents either supports one of the existing or proposed models for single payer reform or, if all are found deficient, develops a single payer model consistent with the College's goals.**

**Resolution 20-F08. Mandating Unique Patient Identifying Numbers**

(Sponsor: New York Chapter)

WHEREAS, there is an increasing risk of identity theft because of the ubiquitous use of Social Security numbers; and

WHEREAS, some patients with similar names and birthdates create the potential for patient errors; and

WHEREAS, there is an increasing use of electronic medical records and data sharing, and a unique patient number would facilitate this process, increasing patient safety; therefore be it

**RESOLVED, that the Board of Regents seeks passage of federal regulation and/or legislation that mandates that all patients be issued a unique patient identifying number other than the social security number.**

**Resolution 21-F08. Requiring Informed Consent Documents to Clearly Disclose Use of Biologic Material**

(Co-Sponsors: Southern California Regions I and II)

WHEREAS, consent forms for research subjects do not usually mention specifically whether biologic/DNA material may be pooled with other studies to create biobanks; and

WHEREAS, current computer/internet technology allows combining of phenotypic/DNA data with geographic data to be able to localize individuals who previously were anonymous; and

WHEREAS, the currently proposed regulations for the NIH DNA biobank would allow the FBI to access the data without a warrant; and

WHEREAS, ACP policy supports the privacy and informed consent of research subjects; and

WHEREAS, the ACP Ethics, Professionalism and Human Rights Committee has been requested to consider this matter but has not done so yet; therefore be it

**RESOLVED, that the Board of Regents lobbies for legislation that requires informed consent documents to clearly disclose whether a research subject's biologic material might be used in a biobank, and if so, whether the FBI would have access to that biobank data without a warrant.**

## **Resolution 22-F08. Adopting Policy to Support Community Rating for Health Insurance**

(Sponsor: New York Chapter)

WHEREAS, community rating is the process whereby an insurance company offers each insurance product in their portfolio at the same price to all individual and group purchasers throughout the same region or market; and

WHEREAS, community rating distributes risk evenly throughout an area and is consistent with the “shared risk” concept that is the essential reason for insurance; and

WHEREAS, community rating significantly reduces administrative costs because one cost and income analysis is performed to determine the price of each product as opposed to the hundreds or thousands of individual company-by-company analyses that need to be done when experience-rated products are sold in a community; and

WHEREAS, the multiplicity of prices offered for the same product in an experience-rated market is confusing to purchasers, costly for businesses to analyze, impedes the ability to compare prices between competitors, introduces extra layers of administrative expenses by engaging brokers, and is inherently unfair to those who pay more for the same product; and

WHEREAS, community rating eliminates incentives for employers to avoid hiring or retaining employees based on their age or health status in order to lower their health insurance costs in an experience-rated system; and

WHEREAS, experience-rating by definition pulls companies with below average costs out of the general community pool and raises the insurance costs for all individual purchasers, small groups and small employers, and all other groups and employers that remain in the general community pool; therefore be it

**RESOLVED, that the Board of Regents adopts policy to support community rating for health insurance as the most appropriate model for commercial health insurance and oppose experience-rating in selling health insurance; and be it further**

**RESOLVED, that the Board of Regents advocates for community insurance rating in both national and state legislative forums, and encourage other medical organizations to join ACP in promoting legislation that requires community rating of health insurance policies.**